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No. 05-380

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IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

— v. —

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., and JILL L. VIBHAKAR, M.D., on behalf of themselves and the patients they serve,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

APPENDIX TO RESPONDENTS' BRIEF IN OPPOSITION

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. DOE 3/29/04

[DOE 141]

Q. So where does the danger, in the sense of danger, where does the danger come from at term in doing an internal podalic version?

A. This was done historically by a man whose name I cannot remember who advocated this procedure in all deliveries, and it was found to be -- to have a very high complication rate in terms of delivering the fetus healthy. This happened 70 years ago, something like that. I mean, it's just not done now, and I think the main reason is that the fetal head is larger, in general, than the rest of the body, and you need the cervix to be fully dilated in order for the head to pass through, so if you do this procedure before the cervix is fully dilated, turn the fetus around and then try to deliver it, the head is going to get stuck.

Q. You're talking about in full term deliveries?
A. Yes, and the head also gets stuck in D & X procedures.
Q. In all of them or only in some?
A. Only in some.
Q. Okay.
A. In a great number.
Q. Thank you, Doctor. Mr. Coppolino also asked you about your nonintact D & E procedures and indicated, you indicated that those were very low risk procedures, and that there was no clinically significant blood loss versus your nonintact D & Es and your intact D & Es; is that correct?

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. M. LEROY SPRANG 4/06/04

[SPRANG 1176]

Q. Are you aware that Dr. Hammond and Dr. Frederiksen are plaintiffs in other lawsuits challenging the Federal Partial-Birth Abortion Ban Act of 2003?
A. I did see that.
Q. Are you aware that both Dr. Hammond and Dr. Frederiksen do D & E procedures through the end of the 23rd week LMP?
A. Correct.
Q. Are you aware that both Dr. Hammond and Dr. Frederiksen perform abortions that they believe are covered by the Act?
A. I'm not sure of that.
Q. Doctor, you have done approximately 20 D & E procedures over the course of your career, all in cases of fetal demise; is that correct?
A. More or less. I'm sure I have actually done more, and it depends on whether you count the 14 weeks, or when I said that I was actually trying to go to ones that were more, 15,

16, 17, if you count 14s, I'm sure the number is higher.
Q. Okay. Well, I won't hold you to exact numbers, Doctor.
A. That's an approximation.
Q. And you estimate that the latest you've performed a D &
E procedure is approximately 17 weeks?
A. That's correct.
Q. And you've done approximately 20 inductions for purposes
of removing a dead fetus; is that correct?
A. I'm sure I've done more. It was just kind of a low

[SPRANG 1177]

estimate so I couldn't be accused of saying I did more than
I did.
Q. Okay. And that was the estimate you gave at your deposition?
A. Yes. Yes.
Q. You acknowledged it was only an estimate?
A. Correct.
Q. And most of the induction procedures that you've performed for the purpose of removing a dead fetus have been
at 20 weeks or later but a few at 18 or 19 weeks; is that
right?
A. Correct. Correct.
Q. And I believe you stated this on direct examination, but
you have never performed with the one exception that you

described, you have never performed a procedure on a live fetus, a termination of pregnancy on a live fetus?
A. With intent of killing the fetus, no. There are people who come into the emergency room at 15 and 16 weeks in labor with infection and stuff and half the baby is in, and half the baby is out. I have been there and I have taken care of them. It was a live fetus, but obviously, it's going to die because it's 15 or 16 weeks.
Q. And the situation that you just described with an inevitable abortion, is that the right term for that circumstance?

[SPRANG 1178]

A. Yes.
Q. And in those situations, you have actually had women present for treatment where the fetus has begun to come through the cervix and is still alive; is that correct?
A. Correct.
Q. Now Doctor, to state the obvious, because you have only done abortions on fetuses that are already dead, you yourself have never induced fetal demise prior to beginning an abortion procedure; is that correct?
A. Correct.
Q. And you don't give formal lectures on abortions to medical students or residents, formal lectures?

A. Using the definition of formal, I have had discussions with them on D & X.
Q. But not in the formal, not where you would set out to do a formal prepared lecture on abortion?
A. I'm just quibbling because at lunch time conferences, I have, you know, their presentations. How formal that is, I'm just hung up on the word formal. I have done it in part, but I'm not sure formal fits the definition.
Q. All right. And it's your testimony that you did not become involved with the issue of abortion until the partial birth abortion debate began; is that correct?
A. To the best of my recollection.
Q. Doctor, throughout your testimony today, you referred to

[SPRANG 1179]

conversations that you have had with physicians who performed -- Sorry about that chair. It really isn't going to move. But you have had, you have discussed conversations that you have had with physicians who perform what you've described as an intact D & X procedure; is that correct?
A. Correct.
Q. But you cannot recall the names or locations or dates involved with any of those conversations; is that correct?

A. I'm sorry. I do not.
Q. Dr. Sprang, when you perform a D & C, you use mechanical
dilators; is that correct?
A. Correct, sometimes, and sometimes use laminaria.
Q. Okay. And also for procedures where you are removing a
dead fetus in the first trimester, you might also use
mechanical dilators; is that correct?
A. Probably, sometimes yes, and sometimes laminaria.
Q. And in those cases, you may use the mechanical dilators
to dilate the cervix up to nine or ten millimeters; is that
correct?
A. Correct.
Q. And in some cases when you're doing procedures beyond
ten weeks, you may use mechanical dilators up to as much as
12 millimeters; is that correct?
A. I don't think, thinking back on it, I think usually the
sets we have on the table, they do have bigger ones, but

[SPRANG 1180]

usually the sets I have on the table, usually I go to ten.
Q. That's usually, but occasionally, you will go past ten;
is that correct?
A. I'm going to have to say maybe because I don't remember

for sure.
Q. You don't recall testifying about that at your deposition?
A. I remember saying it, but as I thought about it, I'm not 100% sure. I'm trying to think we have had bigger dilators on there, but I don't remember if we had to use them.
Q. And for mid trimester induction procedures, you use Misoprostol; is that correct?
A. Say that again.
Q. For second trimester induction procedures, you use Misoprostol?
A. That is my primary drug now. Obviously, I have been doing this a long time long before Misoprostol was around.
Q. All right. I'll confine my questions to your current practice unless I make it clear to you that I'm talking about another time. All right?
A. Yes.
Q. Thank you. Now, in some circumstances you will put in laminaria the day before you administer the Misoprostol and allow the patient to go home; is that right?
A. Correct.

[SPRANG 1181]

Q. She comes back the next day to the hospital, and Misoprostol is administered at that time?
A. Correct.

Q. And you estimate that you personally use laminaria, I think you said, maybe half-a-dozen times. Is that an estimate?
A. Again, it's a guesstimate, yes.
You also used mechanical dilators in some circumstances prior to the insertion of laminaria just in order to make enough space to get some, at least a laminaria in; is that correct?
A. Right.
Q. And when you insert the laminaria, you put in as many as you can reasonably fit, obviously depending on the size of the cervix, when you start out; is that correct?
A. Depending on, literally, I was involved in one this week, and it's unusual because I don't do that many. But it's actually for my partner whose patient had a missed AB. She wanted to induce her, do a D & C the next morning, and it really looked like a tight, firm cervix, and just rather than be too forceful the next day, we just put in a small laminaria in the office. It was a medium and just said you may have some cramping and stuff, and the hope's that tomorrow, the next day, I'm thinking what day it was, she'll

25 come in as an outpatient D & C, and it will just be easier

[SPRANG 1182]

1 to dilate the cervix because there is some risk involved in
2 mechanically forcing. You open it, it may cause laceration.
3 Q. And so you have to take each patient as she comes and
4 decide at that point how many laminaria you can reasonably
5 put in; is that right?
6 A. Correct.
7 Q. And you have not personally done serial laminaria, and
8 by that, what I mean is that the patient has laminaria
9 inserted, goes home, comes back the next day and has
10 additional laminaria inserted?
11 A. We talked about that at the deposition, too. I wasn't
12 sure. It does seem to me that one time one of the residents
13 asked me to do that, so I wasn't involved, but as a routine,
14 no.
15 Q. But you have supervised residents who have done that?
16 A. Correct.
17 Q. And you mention that you are part of a large or maybe
18 the president of a large practice or partnership practice?
19 A. Correct.

Q. And some of your partners will do serial laminaria; is that correct?
A. Correct.
Q. And the risk of laminaria, let me just list and see if you agree these are some of the risks associated with laminaria. Infection, well, infection and trauma to the

[SPRANG 1183]

cervix?
A. Yes.
Q. And those risks are present when there is a single insertion of laminaria; is that correct?
A. Correct.
Q. And I think you mentioned that you can reduce the risk somewhat by the use of prophylactic antibiotics; is that correct?
A. Reduce the risk of infection, yes.
Q. And those risks, the risks of infection or trauma to the cervix are present whenever laminaria are inserted regardless of whether the laminaria insertion is for purposes of a D & E or an induction; is that correct?
A. Correct. A different distinction would be, obviously, the number you're going to use. You're probably going to use much less if you are just going to minimally prepare the cervix or make it a little expeditious the next day than if you are trying to dilate it five centimeters.

Q. If a woman comes in prior to the induction and the physician puts in an amount that he feels is reasonably, can reasonably fit and the physician doing a D & E, would do the same thing, those risks could be the same thing; is that correct?
A. I think so.
Q. And some of the side effects from laminaria are cramps

[SPRANG 1184]

and pain; is that right?
A. Correct.
Q. Doctor, is it true the causes of cervical incompetence have been studied but aren't well understood?
A. That's a fair statement.
Q. Doctor, are you -- Let me ask a different question first. What's the shortest amount of time that you have seen an induction for in the mid trimester, an induction abortion completed using Misoprostol?
A. I mentioned a term delivery in two hours. Probably four to six hours.
Q. Are there any randomized controlled studies looking at whether completion of an induction abortion within four hours could lead to cervical incompetence?
A. Not that I'm aware of.

Q. Are you aware of any studies looking at the effect of laminaria dilation during the second trimester and cervical incompetence?

A. I might be out there. I'm not thinking of one.

Q. And there is no studies that you're aware of looking at laminaria and Misoprostol use together and cervical incompetence; is that correct?

A. People are reporting the results. I'm not sure if you're specifically looking at blood loss, infections, time, I'm not sure they are looking at an incompetent cervix.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. ELIZABETH SHADIGIAN 4/08/04

[SHADIGIAN 1549]

A. The results show that many of the studies looking at induced abortion and pre-term birth do show an elevation in pre-term birth. What that exactly means is women deliver before 37 weeks of pregnancy more often up to a doubling of that effect, when they have had induced abortion, or what we call abortion here.

Q. Yeah. And is this a risk of pre-term birth a risk that is beyond the normal risk of pre-term birth in a pregnancy?

A. Yes. This is when all the other risk factors for pre-term birth have already been looked at and controlled for during these studies.

Q. All right. Now, in your opinion, what does this -- these findings with respect to pre-term birth indicate, with respect to the potential long-term risks of the D & X procedure?

A. The concern is this: The studies we looked at looked

mostly at first trimester abortions, and some second trimester, but even with these abortions in these studies, that there is an almost doubling effect of pre-term birth. And now, in the D & X procedure, we are talking a much greater size of the baby, and this baby being pulled through a partially open cervix such that the mechanism for injury which is purported to be both damage to the cervix, as well as possibly infections. That the potential for damage to the cervix is much greater in a D & X procedure than it

[SHADIGIAN 1550]

would be in a simple first trimester procedure.
Q. Now, Doctor, is it fair to say that your study and the studies that you rely upon don't say that abortion causes pre-term birth; is that right?
A. It does not show that. It says that there might be a correlation between the two.
Q. In your opinion, Doctor, what should women undergoing an abortion be told about the potential long-term complications of the procedure?
MS. CREPPS: Your Honor, I'm going to object on

relevance, and I don't feel this was disclosed as within the scope of the opinions the doctor would be offering.

THE COURT: Well, what relevance does this have to anything we are talking about?

MR. COPPOLINO: Your Honor, first of all, this article was disclosed and it was inquired of at her deposition.

THE WITNESS: I'm not talking about the article.

MR. COPPOLINO: Right.

THE COURT: There is no consent issue in this case, it seems to me directly. I think that issues of consent, as the doctor has spoken about, about people need to know risk that sort of thing. And that's why she is particularly interested in risk, and how it's explained in common terms is perfectly appropriate background. But you're getting

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[SHADIGIAN 1578]

Q. And your concern that there may be a correlation--well, before I get to that question, let me just confirm. You testified that most of these studies are looking at first trimester abortions, or that's the majority of abortions that are considered in those studies; is that correct?

A. Yes, they were probably the majority of the abortions in those studies, that's correct.
Q. And you believe that based on these studies, there may be a correlation between greater dilation in the second trimester and pre-term birth, based on studies showing an association with dilation in the first trimester?
A. Well, my concern is just that really, it's a mixed bag of first and second trimester basically in these studies, and most of them didn't separate those out, unfortunately.
But the concern is you don't dilate as much in the first trimester and you actually dilate more in the second trimester. So the concern is, could there be even more pre-term birth with second trimester abortions or later gestational age ones.
Q. But because those studies are looking primarily at first trimester abortions, in which the method of dilation was most likely mechanical dilators, whereas abortions in the second trimester are being done with laminaria or a combination of laminaria and Cytotec, it's purely

[SHADIGIAN 1579]

hypothetical that there might be a greater risk, based on these studies?
A. Yes. That's the whole point is we don't have studies on

whether they use laminaria or not in whatever trimester, but it is one of the concerns. But it is a theoretical concern, rather than one based completely on solid evidence.
Correct.
Q. And Doctor, was -- did the studies that you included in the review article include a study by Kalish at all, looking at abortions from 14 to 24 weeks?
A. No, I don't believe it did.
Q. Doctor, it's your opinion, isn't it, that it's impossible during a D & E procedure that most of the fetus can be removed in a single pass?
A. I think I said it would be rare, unlikely.
Q. And that's based on your experience performing D & Es and observing D & Es; is that correct?
A. Yes, and from reading reports, yes.
Q. And you agree that the fetus is more friable as a result of demise and, therefore, disarticulation is more likely or may be more likely with a dead fetus than a live fetus; is that right?
A. Would be more likely or more easily performed.
Q. Well, more easily performed, I guess would be appropriate, based on your prior answer?

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. CHARLES LOCKWOOD 4/08/04

[LOCKWOOD 1696]

condition, sepsis of the uterus, typically presents or could it occur at any point in gestation?
A. At any point.
Q. All right. Might that condition be an indication for termination of pregnancy pre-viability then?
A. Well, yeah. I misspoke. It's much more common near term. It's much more common in conjunction with pre-term rupture of the membranes or premature labor, which generally as I have already explained, occurs after 34 weeks. But clearly an infected uterus what we chorioamnionitis, or intraamniotic infection, before viability is an absolute indication for terminating the pregnancy.
Q. And so for sepsis of the uterus, or chorioamnionitis, as you refer to it, is the D & X procedure necessary to safely terminate a pregnancy for a woman who has that condition?
A. Generally speaking, these are women in labor, active

labor. Infection triggers labor. The cervix is already dilated. So you could continue the medical termination.
The fetus is usually dead by that time, or you could do a D & E for sure. I don't see the relative advantages or
disadvantages of the D & X, except that in an infected uterus, the wall may be damaged. The wall of the uterus
may be damaged and thinned, and there may be a theoretical
advantage to minimal numbers of passes in that condition.
And so that might be an advantage to a D & X, but there is

[LOCKWOOD 1697]

no data to drive that.
Q. Let's talk about a couple of heart conditions. What is
peripartum cardiomyopathy?
A. Peripartum cardiomyopathy is a condition which can have
explanations like high blood pressure, but most commonly is
unexplained. Usually presents in the third trimester but it
can occur in the second trimester and it is associated --
the cause is unknown. The patient's in the past had a 50%
mortality rate. There is a 50% recurrence rate in
subsequent pregnancy.
Q. Does that condition generally occur near term?
A. Generally speaking, but not always.

Q. It might be an indication for pregnancy termination pre-viability?
A. It could be.
Q. Is a D & X procedure ever necessary to safely terminate a pregnancy for that reason?
A. Again, all three are perfectly acceptable. The key is to optimize the mother's cardiac condition, before you do the procedure.
Q. If the mother has a serious cardiovascular condition, would you advise her to wait if possible until after 20 to 23 weeks gestation to terminate?
A. Well, it depends on the cardio. I might advise her not to get pregnant. Depends what that cardiac condition

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[LOCKWOOD 1706]

just want to know what the nature of the objection is, and given what the answer was, do you object?
MS. SMITH: I'll withdraw my objection, Your Honor.
THE COURT: All right. Well, the objection is withdrawn. Pardon us. Go ahead.
BY MR. COPPOLINO:
Q. Thank you. Before we get to the specifics of the Chasen

article, I want to ask you a few more questions. What's your response to the argument the D & X procedure is intuitively D & E, because there are fewer instrument passes into the woman's uterus? Is that sufficient, in your view to establish the safety of the dilation and extraction procedure, at 20 to 24 weeks? Such intuitive or anecdotal evidence?

A. One would not use intuitive or anecdotal evidence to firmly establish procedure as an acceptable and preferred alternative clearly. On the other hand, I believe that it does permit it to be used in -- preferably in the setting of studies where its safety is going to be validated, and I think there is compelling enough arguments as to its safety, that I certainly would not want to prohibit its use in my institution.

Q. But in your opinion, Doctor, what would be required to establish the safety of the D & X method of abortion?

A. I certainly would like to see, to start with,

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[LOCKWOOD 1712]

risks of the dilation and extraction, D & X method of abortion. Doctor, have the risks that have been associated

with the D & X method of abortion been established in the medical and scientific literature?
A. There is no literature at this point. The Chasen article will be a point of information.
Q. Now, you believe -- do you believe the risks of D & E and D & X could be comparable?
A. I do.
Q. Do you see any evidence that the D & X procedure is a safer procedure?
A. Beyond the intuitive or theoretical advantages, no.
Q. Now, some circumstances, you previously testified, that the D & X might be reasonable in some circumstances; is that correct?
A. Correct.
Q. Could you ever envision a circumstance in which the D & X procedure would be required, as opposed to a D & E or a medical induction?
A. No.
Q. What do you see, Doctor, as the potential risks of the D & X procedure, both long and short-term?
A. Well, short-term, they would be identical to those of a D & E. I think the theoretical benefit of an intact D & X is fewer manipulations, which might reduce the risks of

perforation. Risk of perforation is not insubstantial. Can be high in some studies as 1.4%. As others as low as .2%, but it's the most feared complication. So that, I think, is the great appeal of the procedure. So that's, at least, a theoretical advantage. The second part of your question was?

Q. I asked you what you saw as the potential of short and long term?

A. That's really the short-term advantage. Obviously the long-term disadvantage, and many people have spoken on this, is the issue of would further cervical dilatation increase the risk of prematurity.

Q. And is that risk, Doctor, of prematurity, in your view, the primary long-term concern with the D & X procedure?

A. I may be very biased on this topic, but, yes. I would view it as the most serious.

Q. Is there any evidence that you're currently aware of that discusses the relationship between abortion and subsequent pre-term birth?

A. Yes, there is.

Q. What does it show?

A. Well, there are conflicting reports, and the largest

reports we talked about briefly at my deposition are from Europe, both from France and Denmark. The French study suggested that abortion, induced abortion, and fairly ill

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[LOCKWOOD 1725]

abnormality. Traditionally, it has been thought to have an 80% mortality rate. It's probably closer to 40%, and we have -- I published on this and others have published on it. We all have our pet theories as to why it happens.

Q. All right. Doctor, is the risk of amniotic fluid embolism with medical -- how would you compare the risk of amniotic fluid embolism using medical induction to that using a surgical abortion?

A. The theory is there is access to a maternal blood vessel, what we call venues sinusoid, in the uterus that would allow the amniotic fluid to enter into the cavity. And that would be associated with a contraction or sudden increase in pressure of the fluid. So you would be a little concerned that surgical procedures, D & Es, D & Xs, might

uncover those blood vessels in a more frequent setting than would a medical abortion. In fact, Steve's paper makes reference to a D & E with an amniotic fluid embolism. I don't think it's a common complication of abortions in general, but I would be a little more suspicious about surgical procedures than I would be about nonsurgical procedures. To be honest, I would be a little more suspicious about D & Es, where there might be an increased risk of trauma than intact D & Xs, where there might be a slightly reduced risk.

Q. Directing your attention to that aspect of the which

[LOCKWOOD 1726]

talks about conversion of a fetus to a footling breech. In your opinion, would conversion of the fetus to a footling breech create a potential risk to the mother?

A. It's possible that there could be trauma to the uterus as one is attempting that procedure.

Q. Is that a potentially serious risk?

A. Well, if you perforate the uterus, it would be, yes.

Q. So, Doctor, is it fair to say that you think there are some risks, some potential risks, to the D & X procedure?

A. I think there is some risk to all medical and surgical abortions.

Q. Is your concern with the D & X procedure primarily with concern to the longer term complications with respect to pre-term birth?
A. Absolutely.
Q. Doctor, in your opinion, is the dilation and extraction method necessary for purposes of diagnostic pathology?
A. Well, no.
Q. And why is that?
A. Well, it depends on what you're trying to -- what the diagnosis that you're interested in would be. If it were a D and A diagnosis, or chromosomal analysis, a piece of placenta or amniotic fluid sample would be sufficient to give you that. If it were an anatomic analysis of the fetal brain, a medical abortion would be the appropriate way to do

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[LOCKWOOD 1751]

A. Yes.
Q. And is there any reason to think that that wouldn't be true for an intact D & E?
A. No.
Q. Okay. And in an intact D & E procedure, the uterus and

cervix are less likely to be exposed to sharp fetal bone and skull fragments; correct?
A. Correct.
Q. Doctor, you've stated you have some concerns about the conversion of the fetus to a breech position; is that right?
A. Correct.
Q. But the Act also prohibits procedures that do not involve conversion to a breech position; correct?
A. Correct.
Q. And moreover, Doctor, the documented risks of internal podalic version relates to periods closer to term when the uterine wall is thinner; right?
A. Certainly as regards the findings, absolutely.
Q. Doctor, you discussed earlier an opinion that you gave at your deposition in which you agreed that clearly, there is a significant body of medical opinion that in some circumstances for some women, an intact D & X may be safer than the available abortion options. Could you turn to page 159 of your deposition at line 20?
A. This is designed, obviously, to drive me insane with the

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[LOCKWOOD 1760]

nitroglycerin has been used in obstetrics to effect rapid uterine relaxation for replacement of uterine inversion where the uterus turns inside out after delivery; isn't that right?

A. Um-hm.

Q. Or for intrapartum external version of a second twin where the uterus has contracted down around the second twin; isn't that right?

A. I'm not sure I would go to that setting, but yes, absolutely.

Q. And it may work in these cases because it works to directly relax smooth muscle tissue which is what the uterus is made of; right?

A. Correct.

Q. But because the cervix is only 15% smooth muscle tissue and the rest fibrous tissue, the nitroglycerin is not effective to dilate the cervix, is it?

A. I did not know you were a physiologist, but the cervix is about 30 to 40% smooth muscle tissue. Depends on the portion of the cervix you're talking about, but in general, you're correct. Nitroglycerin in utero relaxes -- in general, will not cause signature cervical dilatation with some exceptions.

Q. Doctor, believe it or not, I'm very close to the end.

A. I'll believe it when I see it.

[LOCKWOOD 1761]

Q. That's a promise. But first before we end --
A. Trust and verify as Ronald Reagan used to say, but okay.
Q. I just had a couple of questions about the Chasen study first?
A. Um-hm. That's interesting.
Q. Yes. Well, given that you've testified about it, I will go there, too. As you noted, I believe you testified that the risks of morbidity from abortion, while very low, they increase each week of gestation; right?
A. Correct.
Q. And as I think you also noted in the Chasen study, the median gestational age of the women receiving intact D & Es was 23 weeks while the median gestational age of women receiving D & Es in a nonintact procedure was 21 weeks; right?
A. Correct.
Q. And therefore, you would expect, wouldn't you, that the rates of complications of the intact D & E group would be higher; wouldn't you?
A. Yes.
Q. But they weren't higher; were they?

A. No.
Q. Doctor, you also testified that you had an initial concern about the risk of spontaneous preterm birth in the intact group because the spontaneous preterm birth occurred

[LOCKWOOD 1762]

in two of the 17 subsequent births in the intact group that they were able to follow and in two of 45 of the subsequent births in the nonintact group; right?
A. Correct.
Q. And as you noted, the difference between two of 17 and two in 45 is not statistically significant. The numbers are too small; right?
A. Correct.
Q. And as I think you also testified, the two women in the intact group who had spontaneous preterm birth had risk factors; right?
A. Also correct.
Q. And, in fact, the reason that they had abortions in the earlier pregnancy was precisely because they had premature ruptured membrane or advanced cervical dilatation at 23 weeks. Both of these are risk factors for premature labor in future pregnancy; isn't that right?

A. I think I covered all that.
Q. Okay. Thank you, Doctor. I think you covered most of it. I just had a couple of points I wanted to clarify. But now I really am on my last page. Doctor, you stated that your personal belief is that between 20 and 24 weeks, efforts should be made to avoid fetal pain because of the potential there might be fetal pain at that gestational age; right?

[LOCKWOOD 1763]

A. Right.
Q. But there is no basis to distinguish between D & E and D & X from the perspective of fetal pain; is there?
A. None whatsoever.
Q. And the Act doesn't require that anesthesia be given to a fetus between 20 and 24 weeks or at any gestational age in a D & E that did not follow the course described in the Act; right?
A. Unfortunately, true.
Q. And, Doctor, you also stated on direct that you don't believe that restrictions should be placed on physicians performing abortions prior to 20 weeks at all?
A. That's correct.
Q. Right? But the partial birth abortion act is not

limited to abortions performed prior or after 20 weeks, is it?
A. Also correct.
Q. And finally, Doctor, you testified on direct that based on the information currently available, you do not believe that partial-birth abortion should be prohibited at Yale; isn't that right?
A. That's correct.
MS. SMITH: Just one moment, Your Honor. I have no further questions, Your Honor. Thank you, Doctor.
THE COURT: Redirect?

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[LOCKWOOD 1766]

who are undergoing that procedure?
A. Especially from my perspective.
Q. Ms. Smith asked you a question about the dilation process for a D & X. I want to follow up question on that.
Do you agree that a physician can make a decision to attempt a deliberate and intentional D & X after assessing dilation?
A. I think so, yes.
Q. And, Doctor, is it your view that anecdotal evidence and intuition is a sound way to practice medicine when there are other safe, studied alternative procedures available?

A. I agree with almost everything I said in the deposition so far, so I would agree with that one also.
Q. Doctor, even though you agree that the D & X procedure might have comparable safety indications to alternatives, do you also agree that it's never necessary to use that procedure to preserve maternal health in light of other safe alternatives?
A. I would agree with the caveat being that there may be some circumstance that I'm not aware of. I suppose HIV positive, so on, so on and so on, that you never say with a hundred percent certainty, you know, an HIV-positive patient with a placenta previa, you know, you can create a scenario that eventually I'll cry uncle, but for all intents and purposes, the answer is correct.
Q. And in those cases in which you would cry uncle, the

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PLAINTIFFS' EXHIBIT 115

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Title Omitted in Printing]

EXCERPTS FROM DEPOSITION OF DR. JOANNA CAIN 2/10/04

[CAIN 120]

be sure we reviewed.
Q You said it contained no statistical information or other material that you felt was appropriate.
A We didn't use it by itself for that.
Q Right. What was not -- let me ask it this way: What material did you feel was appropriate to be considered by the task force?
A We felt the numerous examples the task force itself could put on the table regarding their experience or need for this procedure, the textbooks, published information about the safety of D&E and this as a subset of D&E, and the significant background and experience of the people at the table, and also information about the safety and alternatives and the safety of alternatives.
Q Okay. Thank you. Let's take a look at the other New York Times. This is an editorial titled "abortion politics." This is Exhibit 16, ACOG 0043.
This document was before the task force during your deliberations?

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[CAIN 178]

comparison to other procedures.
Q Does the statement at Exhibit 7, the draft proposed statement, does this statement reflect the conclusions of the task force with respect to intact dilatation and extraction?
A Yes.
Q. Okay. Did the task force identify any study which discussed the relative safety of intact D&X versus another method of abortion?
A No, not as we had described it for purposes of our debate.
Q Did the task force identify any study on the relative safety of abortion procedures in general which it relied on in reaching its conclusions about this procedure?
A The CDC data, the ongoing data documents,
the safety.
Q Of? In what way?
A D&E second trimester abortions.
Q Okay. And you mentioned the CDC data. What was it about the CDC data which informed the task force's view with respect to the safety of

[CAIN 179]

intact D&X?
A The overall safety in the second trimester.
Q Of D&E?
A D&E, because D&X was not separately coded.
Q Was the task force aware that Dr. Grimes

had written an article in the 1980s regarding the relative safety of abortion procedures?

A I'm sure that members of the task force would have been aware since it probably was quoted also in the textbooks available.

Q Did the task force specifically consider Dr. Grimes's study with respect to the relative safety of abortion procedures?

A Not as a separate study, but as a part of the literature that supports the safety.

Q Well, what I'm asking you is, can you say that wherever it was as a separate study referenced in a textbook, the task force specifically considered the data found by Dr. Grimes in his study the relative safety of abortion procedures?

A I can say that it's likely.

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PLAINTIFFS' EXHIBIT 120

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

[Title Omitted in Printing]

**EXCERPTS FROM TESTIMONY OF
DR. FREDRIK FRANCOIS BROEKHUIZEN 4/5/04**

[BROEKHUIZEN 519]

ALLOW MORE TIME TO GET MORE DILATATION SO I AM NOT TRYING TO FORCE INSTRUMENTS THROUGH INSUFFICIENT DILATATION.

AND THE THIRD ONE IS TO MAKE SURE THAT I DO AS FEW PASSES WITH THE INSTRUMENT AS POSSIBLE AND ACHIEVE MOST OF THE EXTRACTION PART IN THE LOWER PART OF THE UTERUS. AND I ACHIEVE THAT, AS WELL, BY AT SOMETIME IN THE PROCEDURE GIVING EXTRA OXYTOCIC AGENTS THAT ACTUALLY CAUSE MORE CONTRACTIONS DURING THE PROCEDURE, IF THAT IS APPROPRIATE.

BUT THE MAINSTAY IS TO ACHIEVE SUFFICIENT DILATATION, RIGHT, THAT REQUIRES EASY EXTRACTION.

Q. AND DO YOU USE FORCEPS TO EVACUATE THE UTERUS?

A. WELL, IT IS NOT FORCEPS IN THE OBSTETRICAL SENSE.

OBSTETRICAL FORCEPS IS AN INSTRUMENT THAT ONE PLACES AROUND THE FETAL HEAD TO DELIVER THE HEAD. IT IS AN INSTRUMENT THAT -- IT IS REALLY MORE A GRABBING INSTRUMENT. THERE ARE DIFFERENT TYPES. ONE OF THEM IS CALLED THE SOPHER FORCEPS. THEY ARE KIND OF ROUND. THEY ARE KIND OF SQUARED, SERRATED SURFACES THAT CAN CRUSH TISSUE AND HOLD ON TO TISSUE. AND THEY COME IN DIFFERENT SIZES.

Q. AND IS THE PURPOSE OF USING THESE INSTRUMENTS TO DISARTICULATE THE FETUS?

A. THE MAIN PURPOSE OF THESE INSTRUMENTS IS TO BRING FETAL PARTS THROUGH THE CERVIX OR FAIRLY CLOSE TO THE CERVIX. DURING THIS PROCESS OF EXTRACTION, RIGHT, DISARTICULATION MAY TAKE PLACE, BUT IT IS NOT -- THAT IS NOT THE PRIMARY PURPOSE OF THE

[BROEKHUIZEN 520]

INSTRUMENT. THE INSTRUMENT IS TO PROVIDE TRACTION.

Q. AND IS IT -- DOES IT SOMETIMES OCCUR THAT DISARTICULATION DOESN'T HAPPEN IN THE EVACUATION OR EXTRACTION PROCESS?

A. AGAIN, THAT DEPENDS ON THE AMOUNT OF DILATATION. IF THERE

IS SUFFICIENT DILATATION, IT IS POSSIBLE THAT ONE WILL REMOVE MOST OF THE EXTREMITIES AND TRUNK WITHOUT DISARTICULATION.

Q. DO YOU HAVE A PREFERENCE WHEN YOU ARE DOING THE EXTRACTION WHETHER IT COMES OUT INTACT OR DISARTICULATED?

A. I HAVE TO ACCEPT THE SITUATION THAT I ENCOUNTER. BUT THE LEAST PASSES AND THE LEAST DISARTICULATION AND LEAST CRUSHING I PREFER, BECAUSE THAT WOULD ELIMINATE BONEY FRAGMENTS OR SHARP EDGES THAT IN ITSELF COULD, YOU KNOW, DO DAMAGE TO THE CERVIX OR UTERINE WALL OR BLEEDING.

Q. IF DISARTICULATION DOES OCCUR, WHERE IS THE PART THAT IS ACTUALLY BEING DISARTICULATED?

A. THAT COULD BE IN THE UTERUS. IT COULD BE IN THE CERVIX. IT COULD BE -- HAPPEN IN THE VAGINA --

Q. AND --

A. -- OUTSIDE THE CERVIX.

Q. AND DEPENDING ON THE DISTANCE BETWEEN THE CERVIX AND THE INTROITUS, COULD IT BE OUTSIDE THE WOMAN'S BODY?

A. SURE. IT IS POSSIBLE THAT PART OF THE EXTREMITY IS OUTSIDE THE INTROITUS WHEN DISARTICULATION TAKES PLACE.

Q. AND IN CIRCUMSTANCES WHERE THERE IS DISARTICULATION, DOES

25 THE DISARTICULATION OCCUR ONLY AT THE JOINTS OF THE BONES?

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[BROEKHUIZEN 536]

1 D&E AND INDUCTION PROCEDURES AS YOU DO THEM. IN YOUR PRACTICE
2 IS THERE AN OVERLAP BETWEEN D&E AND INDUCTION ABORTIONS?
3 A. WELL, THERE IS AN OVERLAP IN THE SENSE THAT INDUCTION,
4 RIGHT, MAY LEAD TO A D&E PROCEDURE UNDER CERTAIN CIRCUMSTANCES.
5 THE REVERSE IS REALLY NOT TRUE.
6 IT IS AN OVERLAP IN MY PRACTICE THAT I COUNSEL
7 PATIENTS ON BOTH PROCEDURES. AND WHAT IS MOST IMPORTANT FOR ME
8 IS THAT PATIENTS CHOOSE THAT PROCEDURE THAT THEY ARE THE MOST
9 COMFORTABLE WITH.
10 AND SO I, UNDER RARE CIRCUMSTANCES, ALL RIGHT, WOULD
11 I EXCLUDE ONE PROCEDURE OVER THE OTHER.
12 Q. DR. BROEKHUIZEN, IN YOUR PRACTICE HAVE THERE EVER BEEN
13 SPECIAL CIRCUMSTANCES WHERE IN YOUR OPINION IT WAS SAFEST TO DO
14 THE ABORTION IN A WAY WHERE YOU KNEW YOU HAD ENOUGH DILATATION
15 THAT YOU COULD ACHIEVE AN INTACT EXTRACTION OF THE FETUS UP TO
16 THE HEAD?

A. YES, THERE HAVE BEEN.
Q. DID ANY OF THOSE SITUATIONS INVOLVE A D&E THAT WAS PERFORMED FOR A SERIOUS MATERNAL HEALTH CONDITION?
A. YES. ONE OF THOSE THAT COMES TO MIND WAS -- AND THE ONE THAT I ACTUALLY DESCRIBED IN DETAIL IN THE WISCONSIN CASE, WAS FOR A SERIOUS MATERNAL CONDITION WHERE THE GOAL WAS TO DO SERIAL DILATATION, AVOID MEDICATION FOR INDUCTION AND AVOID THE TRADITIONAL D&E-TYPE METHOD.
Q. AND CAN YOU DESCRIBE THE MEDICAL CIRCUMSTANCES OF THAT

[BROEKHUIZEN 537]

WOMAN AND WHY YOU CONSIDERED THAT TO BE THE BEST METHOD OF ABORTION FOR HER?
A. THIS WAS A PATIENT WHO HAD A CONDITION OF SCLERODERMA, WHO HAD SIGNIFICANT PULMONARY HYPERTENSION, HAD SIGNIFICANT OTHER VASCULAR DISEASE, WHO WAS 23 WEEKS AND ONE DAY PREGNANT; WAS TRANSFERRED FROM ANOTHER HOSPITAL TO THE TERTIARY CARE INSTITUTION I WAS WORKING AT THAT TIME. SHE WAS IN THE CRITICAL CARE UNIT. SHE WAS VERY UNSTABLE. SHE WAS ON MULTIPLE MEDICATIONS. AND IT WAS CLEARLY FELT THAT THE

CONTINUATION OF THE PREGNANCY WOULD BE -- WOULD LEAD TO HER DEATH.
THE INTERNAL MEDICINE SPECIALIST AND THE PULMONOLOGIST AND THE CARDIOLOGIST REALLY FELT THAT PROSTAGLANDINS WERE CONTRAINDICATED IN THIS PATIENT.
Q. LET ME JUST INTERRUPT YOU THERE. IS MISOPROSTOL A PROSTAGLANDIN?
A. CORRECT. WERE CONTRAINDICATED IN HER SITUATION. SHE THOUGHT THAT THE WHOLE LABORING PROCESS WITH FLUID SHIFTS AND TIME WOULD BE MORE STRESSFUL FOR HER THAN -- IN OTHER WORDS, INDUCTION WAS NOT THE BEST OPTION.
THE OPTION OF A D&E PROCEDURE WHERE THE PATIENT WOULD NEED TO HAVE ANESTHESIA, WAS ALREADY -- ANESTHESIOLOGISTS WERE VERY CONCERNED ABOUT WHAT ANESTHESIA -- WHAT ANESTHESIA METHOD TO GIVE HER. AND IF THERE WAS A PROCEDURE, THAT WOULD HAVE TO BE AS SHORT AS POSSIBLE WITH THE LEAST AMOUNT OF

[BROEKHUIZEN 538]

ANESTHESIA. THAT WAS KIND OF THE SCENARIO WE WERE CONFRONTED WITH AT THAT TIME.

AND I DECIDED TO PROCEED AT THAT TIME WITH SERIAL DILATATION WHERE WE PLACED LAMINARIA EVERY FOUR TO SIX HOURS. AND THE CONCEPT WAS THAT THAT, IN ITSELF, MAY LEAD TO SUFFICIENT DILATATION THAT WE COULD TAKE THE PATIENT TO THE OPERATING ROOM WITH MINIMAL MEDICATION, HAD SUFFICIENT DILATATION THAT WE COULD DO AT LEAST A PARTIAL EXTRACTION OR MAYBE A TOTAL EXTRACTION.

AND THAT IS WHAT WE SET OUT TO DO UNDER THOSE CIRCUMSTANCES.

Q. AND WHAT ACTUALLY HAPPENED WITH THAT PATIENT?

A. THAT PATIENT WE PLACED THE LAMINARIA THREE TIMES. THE LAST TIME WE WERE UP TO ABOUT FOUR OR FIVE CENTIMETERS DILATATION. AND WHEN WE ACTUALLY TOOK HER TO THE OPERATING ROOM FOUR HOURS LATER THE FETUS HAD COMPLETELY DELIVERED SO WE DIDN'T HAVE TO -- AND, ACTUALLY, THE PLACENTA WAS SITTING IN THE CERVICAL OS. SO BASICALLY WE HAD JUST TO GRAB THE PLACENTA, AND THE PROCEDURE COMPLETED ITSELF.

BUT I WOULD HAVE BEEN PREPARED AT THAT TIME TO -- ASSUMING THAT THERE WOULD HAVE BEEN A PARTIAL DELIVERY AND THE

HEAD STILL THERE, TO DO COMPRESSING AND DECOMPRESSING METHODS.
Q. AND IN YOUR PRACTICE HAVE YOU TREATED OTHER PATIENTS IN SIMILAR SITUATIONS WHERE INDUCTION WAS CLEARLY CONTRAINDICATED, BUT THIS TYPE OF SERIAL DILATATION TECHNIQUE WAS IN YOUR BEST

[BROEKHUIZEN 539]

JUDGMENT THE OPTIMAL FOR THE PATIENT?
A. IN SOME OVER 20 YEARS, CASES SOMETIMES BLUR. BUT I THINK I HAVE DONE AT LEAST TWO OTHER CASES OF SIMILAR NATURE AT LESS GESTATION AGE. BUT, AGAIN, SITUATIONS WHERE IT WAS FELT THAT AVOIDING OF MEDICATION, SURGERY, ANESTHESIA OR MINIMIZING THAT AND SERIAL DILATATION WOULD BE THE BEST METHOD.
Q. AND DR. BROEKHUIZEN, IN YOUR PRACTICE HAVE THERE BEEN OTHER CIRCUMSTANCES WHERE YOUR PATIENT HAD COMPELLING PERSONAL REASONS FOR HAVING A D&E WHERE THE FETUS WAS REMOVED INTACT AND WHERE YOU ATTEMPTED TO DO THAT FOR HER?
A. I HAD A PATIENT THAT HAD WAS DIAGNOSED WITH A LETHAL SKELETAL DYSPLASIA.
Q. THE FETUS WAS?
A. THE FETUS HAD SKELETAL DYSPLASIA FORM OF DWARFISM

INCOMPATIBLE WITH SURVIVAL. MOST PATIENTS UNDER THESE CIRCUMSTANCES, AFTER THE COUNSELING THAT I DESCRIBED BEFORE, SINCE THERE QUITE OFTEN IS A NEED FOR A MORE PRECISE DIAGNOSIS AND AUTOPSY, WE OPT FOR AN INDUCTION METHOD.

THIS PATIENT HAD A PREVIOUS CESAREAN SECTION AND VERY TRAUMATIC BIRTHING PROCESS THE FIRST TIME AND REALLY DID NOT WANT TO HAVE AN INDUCTION. NOT SO MUCH BECAUSE OF THE RUPTURE RISK, BUT REALLY BECAUSE OF THE EXPERIENCE OF GOING THROUGH A LABORING PROCESS.

AND SHE, AGAIN -- AND AT THE SAME TIME SHE REALLY WAS INTERESTED IN HAVING AS MUCH INFORMATION. AND SO, WE NEED

[BROEKHUIZEN 540]

AT LEAST THE TRUNK AND SKELETAL PART. THAT EXAMINATION WAS IMPORTANT FOR HER. AND WE DECIDED TO EMBARK ON THE SAME METHOD AS I DESCRIBED IN THE PREVIOUS CASE WITH SERIAL DILATATION, WHICH COULD LEAD TO LABORING PROCESS, WHICH WOULD BE MAYBE A LITTLE BIT MORE OR LESS PAINFUL OR PHYSIOLOGICAL OR A SIGNIFICANT DILATATION THAT WE COULD TAKE THE PATIENT AND DO A

PARTIAL OR TOTAL EXTRACTION.
Q. AND WHAT HAPPENED WITH THIS PATIENT?
A. THE SERIAL DILATATION IN THE SENSE WAS SO SUCCESSFUL THAT, AGAIN, THIS PATIENT DELIVERED SPONTANEOUSLY. BUT IT WAS VERY SHORT TIME OF LABOR PERCEIVED BY HER. SO SHE WAS -- IT ENDED UP EXACTLY AS WHAT SHE HAD WANTED IT TO BE.
Q. AND HAVE YOU HAD OTHER PATIENTS WHO FELT STRONGLY AGAINST INDUCTION, BUT WHO WANTED AN INTACT FETUS FOR AUTOPSY PURPOSES?
A. PROBABLY SIMILAR SCENARIO. IT IS VERY RARE, BUT ONE OR TWO TIMES.
Q. OKAY. AND I THINK YOU'VE ALLUDED TO THIS ALREADY IN YOUR TESTIMONY: HAVE YOU PERFORMED INDUCTION ABORTIONS WHERE YOU KNEW AHEAD OF TIME THAT DUE TO SOME TYPE OF GROSS FETAL DISPROPORTION THE HEAD OR ANOTHER BODY PART WOULD BECOME LODGED AT THE CERVIX DURING THE INDUCTION AND YOU WOULD HAVE TO COMPLETE THE ABORTION INSTRUMENTALLY?
A. THAT PROBABLY HAS HAPPENED MORE OFTEN THAN THE TWO PREVIOUS SCENARIOS. THE CASE THAT I DESCRIBED IN WISCONSIN A CASE WAS A SITUATION WITH A LETHAL CHROMOSOMAL ANOMALY AND SIGNIFICANT

[BROEKHUIZEN 541]

MACROCEPHALY THAT CLEARLY WAS INCOMPATIBLE WITH SURVIVAL. BUT THE HEAD WAS GOING TO -- HAD ALREADY REACHED PROPORTIONS THAT WERE LARGER THAN THE HEAD OF A BABY AT TERM, WHERE THE ALTERNATIVE WOULD HAVE BEEN TO DO A SURGICAL PROCEDURE LIKE AT THAT TIME THAT REALLY WOULD HAVE BEEN A SCAR AS BIG AS A CESAREAN SECTION SCAR. OR AN INDUCTION AND BEING PREPARED TO DECOMPRESS THE FETAL HEAD AND TO LET THE SKULL COLLAPSE TO ALLOW FOR VAGINA DELIVERY.

AND IN THE CONTEXT OF THE LETHAL ANOMALY THIS PATIENT REALLY DIDN'T WANT TO EXPOSE HERSELF TO A SURGICAL PROCEDURE EXCEPT IF TRAGIC DEVELOPMENT. AND THE PLAN WAS TO INDUCE LABOR. WHEN THERE IS THAT MUCH DISPROPORTION, IT'S USUALLY IN A BREECH PRESENTATION. AND TO BE PREPARED AT SUFFICIENT DILATATION TO BE DECOMPRESS THE FETAL SKULL.

Q. AND WHAT ACTUALLY HAPPENED WITH THAT PATIENT?

A. THAT PATIENT ACTUALLY -- THAT WENT ACCORDING TO PLAN. SHE DELIVERED THE BODY PARTIALLY. AT THAT TIME IT WAS SUFFICIENT

DILATATION THAT I COULD VISUALIZE THE BASE OF THE SKULL AND INSERT A THIN TROCAR TO REDUCE THE FLUID. AND AT THAT POINT, OF COURSE, FLUID AND BRAIN TISSUE WILL APPEAR.

I THINK I STILL NEEDED TO HAVE SOME -- I USED ACTUALLY PREMIE-TYPE OF OBSTETRICAL FORCEPS BECAUSE I STILL NEEDED TO CREATE SOME COLLAPSING OF THE SKULL. BUT I COULD USE THAT TYPE OF FORCEPS AT 6 OR 7 CENTIMETERS OF DILATATION.

Q. DID YOU SAY THE TROCAR WHEN YOU INSERTED IT, WAS THAT UNDER

[BROEKHUIZEN 542]

YOUR DIRECT VISUALIZATION?

A. IT WAS UNDER DIRECT VISUALIZATION.

Q. AND WAS THE FETUS -- IN THAT CASE, WAS THE FETUS ALIVE AT THE POINT WHEN THE HEAD LODGED AT THE OS?

A. I KNOW IN THAT CIRCUMSTANCE THAT THE CORD WAS PULSATING AT THAT TIME.

Q. AND HAVE YOU PERFORMED OTHER SIMILAR ABORTIONS IN YOUR CAREER WHERE YOU KNEW THAT THE HEAD OR ANOTHER VERY LARGE FETAL PART WOULD LODGE WITHOUT BEING ABLE TO COMPLETE THE INDUCTION WITHOUT INSTRUMENTS?

A. YES. THIS CLEARLY HAS HAPPENED MORE OFTEN. I HAD A SITUATION LIKE THIS ONLY A FEW WEEKS AGO.

Q. DR. BROEKHUIZEN, I WANT TO ASK YOU A FEW MORE QUESTIONS ABOUT THESE PATIENTS OR THESE SCENARIOS YOU WERE JUST DESCRIBING.

BEFORE I DO, LET ME ASK YOU: AM I RIGHT THAT YOU DESCRIBED THESE THREE SCENARIOS IN YOUR DECLARATION IN THIS CASE?

A. YES, I DID.

Q. AND DID YOU DISCUSS THEM IN YOUR DEPOSITION IN THIS CASE?

A. I DID.

Q. AT THE TIME OF YOUR DEPOSITION DID YOU ALSO STATE THAT THERE WERE OTHER SIMILAR CASES LIKE THEM?

A. YES, I DID.

Q. AT ANY TIME IN THIS CASE HAS THE GOVERNMENT REQUESTED THAT

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[BROEKHUIZEN 632]

A. THAT'S CORRECT.

Q. DOCTOR, IF YOU ACCIDENTALLY PUSHED THAT SHARP INSTRUMENT INTO THE MOTHER'S BODY, YOU COULD PERFORATE THE UTERUS AND CAUSE SIGNIFICANT BLEEDING, CORRECT?

A. IF ONE MISPLACED THE INSTRUMENT IN THE WRONG SPOT WITHOUT DIRECT OBSERVATION OR VISUALIZATION, I THINK THAT WOULD BE POSSIBLE. BUT THAT'S NOT GOING TO HAPPEN GIVEN THE SCENARIO I WILL BE USING THAT INSTRUMENT.

Q. DOCTOR, IF I COULD REFER YOU TO YOUR DEPOSITION, PLEASE.

PAGE 168.

PAGE 168, IF YOU COULD READ SILENTLY LINE 23 THROUGH PAGE 169, LINE 9.

A. WHICH LINE SHOULD I READ?

Q. 168, LINE 23?

A. OKAY.

Q. THROUGH 169, LINE 9. OKAY. IF I COULD READ THAT OUT LOUD.

"QUESTION: YOU SAID IT'S PREFERABLE TO BE ABLE TO SEE IF YOU ARE USING A TROCAR OR SOMETHING LIKE THAT. WHY WOULD IT BE PREFERABLE TO SEE?

"ANSWER: BECAUSE YOU WANT TO KNOW EXACTLY WHERE YOU GUIDE AND DIRECT THE TROCAR TO.

"QUESTION: WOULD IT BE POSSIBLE IN THOSE CIRCUMSTANCES TO INJURE THE MOTHER WITH THE TROCAR?

"ANSWER: SURE, IT'S POSSIBLE.

"QUESTION: WHAT WOULD HAPPEN IF YOU WERE TO

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PLAINTIFFS' EXHIBIT 121

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. STEPHEN CHASEN 4/8/04

[CHASEN 1573]

and the proximity of the cervix to the vagina and the fetal position would enable me to do a breech extraction, then I will deliver the fetus like that and this will involve either manually, with my hands, bringing one or both of the legs through the cervix into the vagina, proceeding with a breech extraction.

And, in most cases, the degree of cervical dilation will not accommodate passage of the fetal head through the cervix. And in this case my practice is to make an incision at the base of the skull with the scissors, which I can do really under direct visualization, place a suction device within the skull, the brain tissue is aspirated and, typically, the head then delivers easily.

Q. And what do you do in the event that you are not able to --

THE COURT: Excuse me.

Does that mean because the skull collapsed?

THE WITNESS: Yes.

THE COURT: That it delivers easily?

THE WITNESS: Once the skull has collapsed.

THE COURT: Okay.

Go ahead, Mr. Hut.

BY MR. HUT:

Q. When you are not able to achieve a breech extraction and a relatively intact extraction, how do you evacuate the uterus in a D&E?

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[CHASEN 1606]

time the process of maceration, whereby the tissue in the organs can begin to decay, could have occurred, and that could interfere with pathologic evaluation.

THE COURT: What is that, Doctor, pathologic evaluation? Is that the term?

THE WITNESS: Autopsy or evaluation by a pathologist.

THE COURT: Thank you.

Q. Dr. Chasen, the way you perform intact D&E's, is there maceration involved with that procedure?

A. No, there isn't.

Q. Does intact D&E offer particular safety advantages for particular patients, Dr. Chasen?
A. Yes, it does. For women with certain medical conditions D&E would -- I'm sorry. Did you ask D&E with intact extraction or D&E in general?
Q. D&E with intact extraction.
A. Intact extraction variation of D&E minimizes the risk of uterine perforation and I believe minimizes the risk of hemorrhage and can shorten the procedure time. Women who are having the procedure because of medical complications are least able to sustain the complications or to tolerate complications. So in these women, D&E with intact extraction, in my opinion, would have specific advantages.
Q. You mentioned hemorrhage. What types of patients, Dr. Chasen, are at particular risk for hemorrhage?

[CHASEN 1607]

A. Patients who may have decreased amount of clotting factors because of a metabolic condition or an inherited condition like hemophilia could. Patients with cancer who have undergone chemotherapy, which can prevent the body's ability to produce

clotting factors, also can be prone to hemorrhage. In women that may have ruptured the membranes and may have a significant likelihood of already having an infection in the uterus, that increases the risk of hemorrhage as well.

Q. Have you performed abortions for such patients either with a shortage of clotting factors or premature rupturing of membranes?

A. Yes, I have, as well as on chemotherapy.

Q. By what procedure or variation did you perform the abortions in those cases, if you recall?

A. I don't recall.

Q. Why, in your opinion, would intact D&E offer safety advantages for women who are at particular risk for hemorrhage?

A. In that the intact variation of D&E reduces the need to insert forceps, which can be associated with uterine rupture. The insertion of forceps while removing the fetus could also disrupt the placenta prior to the fetus being removed.

And bleeding from the placental sac can be ongoing during the procedure. Using the intact variation, which doesn't involve use of forceps to remove the fetus and which does not involve placental disruption prior to the removal of

[CHASEN 1608]

the fetus, hemorrhage would be less likely to occur.
Q. In your experience, Dr. Chasen, does intact D&E offer safety advantages over induction for women at risk for hemorrhage?
A. Yes, it does.
Q. Why is that?
A. In women at risk for hemorrhage, one common complication of medical induction is infection, and another common complication is retained placenta. Oftentimes they coexist. Both are significant risk factors for hemorrhage.
THE COURT: Does infection ever occur in intact D&E's?
THE WITNESS: Almost never.
THE COURT: Does it ever occur?
THE WITNESS: Infection can occur in any surgical procedure, but I have never had a patient with --
THE COURT: Does hemorrhage, bleeding, occur in intact D&E?
THE WITNESS: Hemorrhage can occur in any procedure. I have never experienced it in doing a D&E with the intact extraction.
THE COURT: But it can occur?
THE WITNESS: It can occur in any surgical procedure.

THE COURT: That's all I asked, Doctor. Next question.

Q. Are there occasions, Dr. Chasen, that you have encountered

[CHASEN 1609]

where a patient needs an abortion urgently to protect her health?

A. Yes, there have been some situations.

Q. What are some of the situations that you have encountered, Doctor?

A. I have encountered women that have a dilated cervix in the second trimester or have ruptured membranes in the second trimester, and both of these conditions can be caused by an infection in the uterus or an infection can happen secondary to it. Continuing the pregnancy under these circumstances can lead to a bodywide infection called sepsis, which can be life-threatening.

I have also taken care of women that have medical conditions. One specific to pregnancy is preeclampsia, which is a complication involving hypertension and deteriorating kidney function. Although that typically happens close to

term, rarely it can occur in the second trimester, and continuing the pregnancy under these circumstances could be life-threatening to the women.

THE COURT: You could be said to be doing this to save their lives?

THE WITNESS: Yes, it could be.

A. And there are also women with preexisting medical conditions, including heart disease, where, because of the physiologic condition of pregnancy, they may experience

[CHASEN 1610]

deterioration in their health, and sometimes relatively rapid deterioration of their health, and abortion is indicated as a life-saving procedure.

Q. Are these situations always life-threatening or are they sometimes health-threatening?

A. They are not always life-threatening, but they certainly could be, and they are certainly health-impairing.

THE COURT: And risk possibly to life?

THE WITNESS: Yes.

THE COURT: Next question.

Q. Would you do an intact D&E in cases where a pregnancy termination is urgently needed?

A. Yes.

Q. Are there any advantages, in your opinion, that an intact D&E would offer in such circumstances over a dismemberment D&E?

A. Again, if this woman, if my patient needs to terminate the pregnancy urgently, then she is such a patient that would be most likely to suffer from an operative complication, and these operative complications in my opinion are more common with a dismemberment form of D&E.

Q. As between induction and intact D&E, what procedure would you recommend in circumstances where a patient needed pregnancy termination on an urgent basis?

A. I would recommend D&E.

Q. Why is that, Doctor?

[CHASEN 1611]

A. Again, whereas normally for a D&E, especially after 20 weeks, I will do laminaria insertions for 48 hours, I can do multiple laminaria insertions in a shorter time interval, and I can generally accomplish the procedure from first laminaria insertion to evacuation within a 24-hour window. A medical induction could take a few hours, but in many cases it could

take considerably longer than 24 hours, and I don't know at the outset of the procedure what will happen.

The other safety advantages that I have cited previously favoring D&E over induction certainly apply here.

Q. Dr. Chasen, when you set out to perform an abortion, can you assure that the D&E that you perform will proceed intact?

A. No, I can't.

Q. How, then, can you say that the procedure offers advantages?

A. In some cases, in the cases in which I am able to do it based on cervical dilatation, proximity of the cervix to the vaginal opening and fetal position, it offers safety advantages. These women are typically at a more advanced gestational age.

If I could do it with intact extraction, then I could do it without introducing forceps into the uterine cavity, which increases the risk of trauma to the uterus, including rupture, and I can remove the fetus without exposing the maternal tissues to sharp edges of bony fragments and I believe

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severe allergic reaction throughout the body, particularly in the blood vessels in the lungs. This could cause essentially a collapse of blood pressure. The most common outcome of amniotic fluid embolus is death.

Q. Did any of what you described as these three major complications occur in the group of patients who had had intact D&E?

A. None of these complications happened in those patients.

Q. Did you find that the difference between the two groups in terms of the major complications was at a level of statistical significance?

A. It was not.

Q. Were there any differences, Dr. Chasen, in the demographics of the studies to cohorts?

A. There were differences.

Q. What were those?

A. I think the most significant difference is that the median gestational ages, the women who had D&E with intact extraction were closer to 23 and 24 weeks as a whole group, and the women that had D&E with disarticulation or dismemberment were more likely to be closer to 20 and 21 weeks. So as a whole the

women with the intact extraction variation, that group were of more advanced gestation, with bigger fetuses and more placental tissue. That was one difference.
Q. Let me interrupt you. Why, in your judgment, is that

[CHASEN 1629]

difference in demographics a significant one?
A. It is significant because the rate of complications, and indeed the rate of maternal death, related to abortion in studies clearly demonstrates an increased risk with advancing gestational age. Complication rates are also higher with advancing gestational age. So the fact that women who had D&E with intact extraction were as a whole at more advanced gestation suggests that they were at higher risk for complications. They were at higher risk for complications.
Q. Dr. Chasen, were there any differences in the intraoperative variables as between the intact D&E cohort and the cohort for D&E with dismemberment?
A. We did not observe a difference in operative times or in estimated blood loss between the two groups.
Q. How about with respect to laminaria use?
A. There were more women in the D&E with intact extraction who

were undergoing this procedure because they had dilated their cervix prematurely and were terminating, because they were at high risk of miscarrying prior to viability or shortly thereafter, and after counseling they chose to terminate.

These women who had advanced degrees of cervical dilation already did not require laminaria for cervical dilation before evacuation. And in that advanced degrees of dilation facilitate intact extraction, there were more of these women proportionally speaking in the intact extraction group

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[CHASEN 1632]

the intact extraction group, I think we were comfortable making the conclusions that we did.

Q. Dr. Chasen, what was the conclusion in your study as to the relative safety of the two variations of D&E analyzed?

A. Our main conclusion was based on the data, based on the fact that the complication rates essentially were identical. They were both 5 percent. Or one was 4.9 percent and one was 5 percent. In our institution women undergoing D&E at these

gestational ages, there was no difference -- the complication rates between women undergoing the two procedures was comparable.

Q. Do you still adhere to that conclusion?

A. I adhere to the conclusion that both variations are safe and that there is a low complication rate, especially of major complications, for both procedures. However, given that I would consider the women who had D&E with intact extraction to be at higher risk for complications in that they were at more advanced gestational ages, with larger fetuses, with more placental volume, and more of these women had ruptured membranes or cervical dilation, which can be associated with a preexisting infection, which can be associated with hemorrhage, for instance, that this was a higher risk group for complications, the fact that we achieved the same level, the same rate of complications in these two groups, who I don't think I would consider at equal risk of complications -- and in

[CHASEN 1633]

fact we did not see any severe complications in the patients

with intact extraction -- in my opinion, we could take it a step further and say this is consistent with our belief that D&E with intact extraction has safety advantages.

THE COURT: Is that statement included in your report that you just made?

THE WITNESS: In the study --

THE COURT: Or did your report stop with they were equal?

THE WITNESS: Explicitly, they stopped with they were equal.

THE COURT: So this is yours that you are adding on, but it is not in your report?

THE WITNESS: It is in the study that we believe we prevented adverse outcomes in that we were able to implement our medical judgment as to the right type of evacuation procedure and that we believe we prevented complications in women in whom intact extraction was feasible. That is in the paper.

Q. Dr. Chasen, are there other factors reported in the paper apart from the same complication rate for different gestational ages that support the conclusion you just articulated?

A. I'm sorry. Could you repeat the question?

Q. Sure. You just indicated that you thought that the same complication rate for cohorts with different gestational ages

[CHASEN 1634]

suggested possible advantages to intact D&E.

THE COURT: Stop whispering, Mr. Hut. Speak up.

Q. I wondered whether there were other results in the study that support that conclusion to which you just testified.

A. Other than complication rates, in terms of achieving similar procedure times and similar blood loss, again, that indicates that if you have equal results in those intraoperative factors but you have one group -- generally, procedure times in my experience relate to gestational age and how much fetal and placental tissue needs to be removed. How long it takes for the uterus to contract down and stop bleeding can depend on the size of the uterus at the outset of the procedure. And advanced gestational age of the uterus is bigger. Again, with equal operative times and equal blood loss, that suggests to me that there are safety advantages to D&E with intact extraction.

MR. HUT: Your Honor, plaintiffs offer in evidence Plaintiffs' Trial Exhibit 23A, which is a copy of the Chasen study.

THE COURT: Any objection?

MS. GOWAN: Your Honor, we did object to it on hearsay groups, I believe. Yes, your Honor, we object to that on hearsay. It is an unpublished article. It is a statement by a party in the case.

THE COURT: For whatever that is worth, I will let it

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[CHASEN 1638]

BY MR. HUT:

Q. Based on your experience with KCL, how easy is it to accomplish a KCL injection?

A. In the easy cases it is easy and in the hard cases it can be impossible.

Q. Are there any women who you have seen for whom it, an injection cannot be done?

A. Yes, there are.

Q. Can you identify some of those, Doctor?

A. There are some women, they may be obese; they may have -- the uterus may be distorted by large fibroid tumors, the benign

tumors that are not uncommon, especially as women get older;
where the fetal heart or the fetal umbilical cord or the amniotic cavity may be not anywhere near close proximity to the
surface of the maternal abdomen and the farther away you get
the deeper the penetration that the needle is required to
achieve, the more difficult these procedures can be.
There are some types of fetal abnormalities that can
be associated with no production of amniotic fluid and any
ultrasound guided procedure relies on fluid to surround the
fetus to be able to see it. The sound waves required to see
something on ultrasound need a contrast from liquid to solid
and you need amniotic fluid to see what you are doing.
In cases where there is a fetal anomaly and there is
no amniotic fluid it is very, very difficult to visualize

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PLAINTIFFS' EXHIBIT 122

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. MITCHELL CREININ 4/5/04-4/6/04

[CREININ 689]

BY MS. KRASNOFF:
Q. ACTUALLY, BASED ON YOUR EXPERIENCE, YOU MENTIONED THE LIVER TRANSPLANT AS WELL. IS THERE ANOTHER CASE, AN ACTUAL PATIENT THAT COMES TO MIND THERE?
A. THERE WAS -- I HAVE HAD A PATIENT WHO HAD FETAL DEMISE WHERE THE SITUATION AROSE, AND IN THAT SITUATION, I WOULD HAVE CHOSEN TO DO AN INTACT REMOVAL IF WE GOT TO THAT POINT, BUT SHE PASSED AWAY.
Q. AND CAN YOU EXPLAIN WHY IN THAT CASE INTACT REMOVAL WOULD HAVE BEEN PREFERABLE?
A. BECAUSE HER LIVER HAD COMPLETELY FAILED, AND SHE HAD NO WAY OF CLOTTING.
Q. WOULD IT HAVE BEEN SAFE TO DO AN INDUCTION IN THAT CASE?
A. NO, THAT WOULD HAVE KILLED HER WITHOUT A DOUBT IN TRYING TO GET HER THROUGH THE INDUCTION.

YOU HAVE -- INDUCTIONS IS A VERY PROLONGED PROCESS, AND THERE IS GOING TO BE BLEEDING THROUGHOUT THE INDUCTION. SO AS THE FETUS BEGINS TO PASS THROUGH THE BIRTH CANAL OR THE PLACENTA BEGINS TO SEPARATE, HERE IS A WOMAN WHO CAN'T CLOT AT ALL. I WOULD WANT TO DO A PROCEDURE ON HER UNDER VERY CONTROLLED CIRCUMSTANCE THAN TO MAKE THE PROCEDURE GO QUICKLY. YOU HAVE A PERIOD OF BLEEDING, BE A SHORT TIME, TO HAVE SUPPORT PEOPLE AROUND. THERE IS A BENEFIT OF BEING IN AN OPERATING ROOM WHERE IT'S LIKE AN INTENSIVE CARE UNIT, IN A SENSE. YOU HAVE THE ABILITY TO HANDLE THINGS ACUTELY.

[CREININ 690]

SO A PROCEDURE IN THAT SITUATION WOULD BE PREFERABLE. AND THESE ARE SITUATIONS ALSO WHERE THE MATERNAL FETAL MEDICINE SPECIALISTS IN OUR DEPARTMENT ARE PART OF THE CONSULTING TEAM, AND THE MAJORITY OF THE PATIENTS LIKE THIS THAT HAVE SEVERE, ACTUALLY ALMOST ALL OF THE PATIENTS WITH SEVERE MEDICAL CONDITIONS ARE REFERRED TO ME BY THE MATERNAL

FETAL MEDICINE SPECIALISTS IN OUR DEPARTMENT.
Q. WE ARE GOING TO SWITCH TOPICS A LITTLE BIT.
I KNOW YOU WERE LOOKING AT THE CLOCK, YOUR HONOR.
DO YOU WANT TO GO TO FOUR?
THE COURT: I AM ASSUMING YOU WILL BE FINISHED BY
FOUR WITH THE DIRECT?
MS. KRASNOFF: WITH THE DIRECT? YES, YOU'RE
INCORRECT.
THE COURT: WE WILL GO TO FOUR.
MS. KRASNOFF: CLOSE THOUGH.
BY MS. KRASNOFF:
Q. WE ARE GOING TO SWITCH AND TALK ABOUT CERVICAL
INCOMPETENCE.
WHAT IS CERVICAL INCOMPETENCE?
A. CERVICAL INCOMPETENCE IS A WEAKENING OF THE STRUCTURE OF
THE CERVIX THAT WOULD NOT ALLOW IT TO STAY CLOSED WITH PRESSURE
FROM A GROWING PREGNANCY.
SO, THE CERVIX IS ACTUALLY ABOUT 80 PERCENT
CONNECTIVE TISSUE AND 20 PERCENT MUSCLE, WHEREAS THE UTERUS IS

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PLAINTIFFS' EXHIBIT 123

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. MARILYNN FREDERIKSEN 4/6/04

[FREDERIKSEN 1141]

THE WITNESS: No, that is not. I said the scissors would be important to make an incision at the base of the skull, but I don't use suction. I use my finger to disrupt the contents of the cranial cavity, to thereby collapse the skull and allow delivery of the fetus.

THE COURT: So you use your finger to get the contents of the skull out rather than sucking the contents of the skull out, is that correct?

THE WITNESS: Yes.

THE COURT: Next question.

Q. Do you actually remove the contents of the skull, Doctor?

A. Not necessarily.

Q. Dr. Frederiksen, you testified yesterday about the general safety advantages of an intact to D&E. Do you have an opinion

regarding whether an intact approach to D&E offers particular safety advantages for women with certain medical conditions?
A. I do.
Q. What is that opinion?
A. Women with certain medical conditions are sometimes better served by intact D&E than any other method of intact termination because the fetus comes out as intact as possible with less lacerations to the cervix and less chance of prolonged procedure, hemorrhage, or of tissue left within the uterus, thereby providing a nidus for infection.
Q. Can you give some examples of particular medical conditions

[FREDERIKSEN 1142]

for which an intact D&E would offer additional safety advantages?
A. Acute fatty liver of pregnancy, sepsis, where you have an unstable patient and significant infection within the uterus.
Those are two that come to mind.
Q. Let's talk first about sepsis. Why would an intact approach to D&E offer particular advantages for a woman at risk for sepsis?
A. A patient who is septic, and the particular circumstances is not only that there is chorioamnionitis, or an infection in

the uterus, but there is infection in the uterus, she can be hemodynamically unstable or in shock with low blood pressure, high pulse, and potential of metabolic acidosis injuring the lungs.

THE COURT: Doctor, going back to hemo, what was the term?

THE WITNESS: Hemodynamic.

THE COURT: Do you want to define these terms? You get talking in very technical terms. We aren't going to understand it.

THE WITNESS: Hemodynamics is the function of the cardiovascular system that maintains pulse and blood pressure. In a patient in septic shock, you have very, very low blood pressure and a very high pulse. That lack of cardiac output decreases blood to the kidneys, to the lungs, and to other

[FREDERIKSEN 1143]

maternal tissues. In that situation, you can have the development of metabolic acidosis.

THE COURT: What is that?

THE WITNESS: That is a change in pH.

THE COURT: What is that?

THE WITNESS: The acid/base balance. Is that

sufficient?

THE COURT: What does that mean?

THE WITNESS: Acid/base is the amount of acid or base that is in the maternal bloodstream. It is usually kept in a very, very tight range physiologically. When you do not have adequate profusion of maternal tissues, the maternal tissues continue to make acid and waste products and they cannot be gotten rid of by the normal physiologic processes. Therefore, you get the development of more acids in the bloodstream.

With that, you can also develop what is called disseminated intravascular coagulation. That is a process by which you consume the clotting factors in the bloodstream as well as is the platelets. Platelets are small, subcellular elements of the clotting system which are usually the first mechanism by which the body stops blood loss in capillaries or in vessels.

In a situation with metabolic acidosis, you also have the development of disseminated intravascular coagulation, a consuming of the clotting mechanism. Therefore, the patient is

at increased risk for hemorrhage.

When you have a patient who is at increased risk for a hemorrhage, an intact D&E would be the optimal way to empty the uterus, because you would decrease the chances that the cervix would be lacerated during the process of delivery of the fetus.

You also decrease the risk of hemorrhage, and hemorrhage in the second trimester is the highest cause of complications.

Q. Does it affect the procedure time, Doctor?

A. Procedure times for second trimester terminations with an intact or near intact delivery of the fetus are actually shorter.

Q. Than for a procedure with more dismemberment?

A. That's correct.

Q. Could you do an induction for such a patient who is at risk for sepsis?

A. An induction is possible, but, again, we are taking the patient through a riskier procedure and a longer procedure.

THE COURT: Longer for you, too, isn't it, Doctor?

THE WITNESS: Yes. But my focus is really on getting the patient delivered in a situation where she has the potential of multiorgan system failure and death.

THE COURT: But it is for a time of yours, which means less time for other patients, right?

THE WITNESS: If I have a patient in septic shock, I don't have the ability to take care of any other patient while

[FREDERIKSEN 1145]

I am taking care of that patient.
THE COURT: But also, if you do this procedure rather than induction, it takes more of your time, therefore you can devote less time to other patients, correct?
THE WITNESS: Actually, an induction may not take as much time, because the induction process has actually begun and the whole length of time that the patient is undergoing induction I may be doing other things.
Q. Doctor, you said that if you have a patient in septic shock, you are not treating other patients. Is that regardless of what type of procedure you are using the terminate the pregnancy?
A. Yes.
Q. You also mentioned something called acute fatty liver of pregnancy, is that correct?
A. Yes.
Q. What is that?
A. Acute fatty liver of pregnancy is caused by the fetus

having an inborn error of metabolism of long-change fatty acids. Long-chain fatty acids were the structural molecules by which many of our cell membranes and other fats are stored within the body. If the fetus cannot metabolize long-chain fatty acids, they can accumulate in the meantime and be then transferred to the maternal cardiovascular system for excretion. In acute fatty liver pregnancy, the biopsy of a

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[FREDERIKSEN 1225]

the back of the skull and reducing the head with a scissors, right?

A. Yes.

Q. To disrupt the fetal brain, you use your finger, and that compresses the contents of the head and allows it to pass through the cervix?

A. Yes.

Q. When you do a D&X in breech presentation, you grasp the fetal foot, and with careful manipulation of the fetus you deliver the fetus to the trunk, right?

A. Yes.

Q. Then you essentially do a breech delivery, where you are

left with the fetal head inside the cervix, right?
A. Yes.
Q. Then you either compress the head or you enter the skull with scissors and disrupt the fetal brain, correct?
A. Correct.
Q. In your view, Doctor, D&X does not necessarily involve converting the fetus to a breech presentation, does it?
A. Correct.
Q. If the fetus is in head-first presentation and if you take certain other steps, you still could be doing a D&X, right?
A. Correct.
Q. You have done the D&X when the fetus was in head-first presentation without converting it to a breech, right?

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PLAINTIFFS' EXHIBIT 124

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. CASSING HAMMOND 3/31/04-4/1/04

[HAMMOND 565]

THE WITNESS: No.
THE COURT: Did the patient know you perforated the uterus?
THE WITNESS: Absolutely. We always share that with the patient.
THE COURT: Go ahead. Next question.
Q. Dr. Hammond, I believe you were talking about the reasons why it is your opinion that the intact approach to D&E is the safest way to perform a D&E. I think you mentioned the decrease in the number of passes of instruments into the uterus. Would you continue with your answer, please.
A. Like I was saying, there are many other reasons that I think that it is safer to use the intact procedures. Another reason is simply that there is less of a chance to lacerate or

to make a cut in the cervix. If you are doing this relatively intact, you have fewer bony parts of the fetus that are exposed that can cut into the cervix as you remove them from the patient. So the more intact the fetus, the less chance there is for those to cut the cervix and injure the patient.

Another reason is simply the degree of surgical control that we have. With very intact procedures, when I have control over the fetus external to the cervix, I can see a large portion of the procedure that I am doing. I am not having to blindly grope inside the uterus like I am with a more disarticulated or dismembered D&E, and therefore have a

[HAMMOND 566]

drastically lower likelihood of perforating the uterus and injuring the cervix, because it is all exposed.

I also, particularly if this has proceeded intact to the level of the fetal head, have complete control of the head. One of the hardest parts of a D&E is if the head has been dismembered and you have to, because it is usually the last

thing you have to extract, if you have to try to again grope blindly inside of the uterus, it is entirely based on your experience with the instruments and it is not something that you have the degree of surgical control over at that time. So I think surgical control is another issue.

I also think that there is less likelihood of retained products, retained material if we are doing one of these as an intact or relatively intact procedure. One of the problems with a more disarticulated D&E is you have to have some way of accounting for what you have removed from the uterus. All of us, after doing these for a while, get a gestational age-appropriate concept of what is an appropriate amount of fetal as well as placental material. But clearly, if I have watched the intact fetus delivery, I know, without having to do anything further, that I have removed the fetus intact and haven't left something behind.

I also think that this is safer in the case of some fetal anomalies. I also think that the intact D&E decreases our time in the OR. I don't mean that from a matter of

[HAMMOND 567]

convenience. It is simply the fact that one of the kind of standards in surgery is the less time that the patient is exposed to the procedure, the less duration of anesthetic she is receiving, the less likelihood her complications. If I can do this intact rather than having to constantly reach in and remove more and more parts, I can accomplish the D&E faster.

Q. Doctor, let's talk about your testimony that intact D&E reduces the risk of uterine perforation because of fewer passes with instruments. Can you explain how uterine perforation would occur.

A. It can occur in one of two ways: Either because the instrument goes through the wall of the uterus or because a fetal part that has been disarticulated, particularly a sharp fetal part, is pushed by the instrument or something else inside the uterus through the wall of the uterus.

Q. What, if any, health risks are associated with uterine perforation?

A. It varies. Uterine perforations are actually more common with D&E and with first trimester abortion than many people

realize. We know that from studies where they have done simultaneous first trimester abortions and tubal ligations so that they were looking into the abdomen while they were doing it.

We know that most small perforations probably cause no harm, but certain perforations cause more harm than others. If

[HAMMOND 568]

it is a large perforation at the top of the uterus, the patient can bleed from it. But usually we can fix the uterus without any long-term sequelae, long-term problems.

On the other hand, a similar size perforation on the side of the uterus, which is where the blood supply for the uterus comes in, the uterine artery cones from the side wall of the pelvis, if you poke a hole or perforate the side of the uterus, the patient can have catastrophic hemorrhage quite rapidly, because she is bleeding from very large blood vessels.

Q. Doctor, are the risks associated with uterine perforation serious?

A. Again, there is a wide range of uterine perforations. In

most cases, no, but they can be. It can vary from simply needing extra observation in the hospital to some patients requiring surgery to repair the uterus. And in other cases the only way we can control the hemorrhage is by performing a hysterectomy, which is obviously serious, because at that point the patient has lost her reproductive capacity.

Q. Why does intact D&E reduce the risk of uterine perforation?

A. Again, there are several reasons. First of all, I am just not reaching into the uterus as frequently. Secondly, when I am reaching in, I am not having to rely solely on feel. I have greater control of the fetus, often operating almost directly in front of me external to the cervix. So I am not reaching into the uterus as frequently, I don't have dismembered fetal

[HAMMOND 569]

parts in the uterus that can poke through the uterus, and I have far better surgical control throughout the procedure.

Q. Doctor, you also testified that one of the advantages of an intact D&E is reducing the risk of cervical laceration or

uterine perforation due to the fact that the presence of sharp bony fetal parts is reduced. First of all, can you tell us, what is cervical laceration?

A. It is a cut or a tear in the cervix, a scrape in the cervix.

Q. What causes the presence of sharp bony parts in the first place?

A. Disarticulation or dismemberment of the fetus.

THE COURT: Have you ever lacerated a cervix?

THE WITNESS: I am sure at some point that I have, your Honor. I don't specifically recall a circumstance right now.

Q. Doctor, why is the presence of sharp bony fetal parts associated with laceration and perforation?

A. In terms of perforation, obviously if you have a sharp object that is inside of the uterus and you are reaching in somewhat blindly into the uterus to grasp that sharp object, you can either directly push that object through the uterine wall or indirectly do so as whatever other parts jostle that object inside the uterus.

In terms of cervical laceration, if you have exposed

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[HAMMOND 586]

intact after a half hour, we start leaning in the direction of delivering it. We probably also do this simply because a lot of our induction termination patients have epidural anesthetic already on board, they are already comfortable, and it is also a good time for the patient to go ahead and effect delivery.

Q. Doctor, yesterday, when we finished at the end of the day, we were in the process of talking about the safety advantages of an intact approach to D&E, and you had mentioned that there were general safety advantages. You had also mentioned that intact D&E might offer particular safety advantages for certain patients, is that correct?

A. That's correct.

Q. What types of patients does that apply to?

A. I think there are several types of patients it would apply to. People with certain bleeding disorders, people with chorioamnionitis, people with certain types of heart disease can all benefit if I am able to do their procedures relatively intact than by dismemberment.

Q. Let's take those one at a time then. Why would an intact D&E offer particular safety advantages for women with bleeding disorders?

A. As we had talked about, a patient who has a bleeding disorder is at a greater risk of hemorrhage. During the course of a D&E, if I am able to perform the D&E relatively intact for reasons that I think I have already covered, there is less of a

[HAMMOND 587]

risk of perforation, less of a risk of cervical laceration, which would be complications that would be even more devastating to a patient who has a particular bleeding problem. So to the extent I am less likely to run into those complications in these patients, it is safer for me to do the D&E as intact as possible.

I also think it is safer because of the control we have over the timing of the procedure. Keep in mind that -- I'll stop there. I really was thinking more of induction versus D&E, which we are not talking about. I'm sorry. Go ahead.

MS. CHAITEN: Your Honor, there seems to be some

feedback or something coming from the microphone as the witness is speaking. We are hearing buzzing behind us, and it is making it difficult to hear the witness.

THE COURT: Michael, could you ask the technician to come up. Do you want to take a 5-minute break here? Is it at your end, Ms. Chaiten?

MS. CHAITEN: I am hearing it behind me.

MS. GOWAN: I think the witness is too close to the microphone.

MS. CHAITEN: Am I too close to the microphone? Let's try that.

THE COURT: Back away a little bit. Try to put your hand between your mouth and the microphone. At least that is

[HAMMOND 588]

something somebody has told me. See if that works.

A. Can you hear me without hearing the reverberation?

Q. Yes. I am hearing you without the reverberation.

A. I will stay back away from the microphone.

Q. Thank you. I hope I didn't interrupt you. Were you done with your answer as to why you think bleeding disorders offer a particular --

THE COURT: I think he said, I'll stop here.

Q. I didn't ask you, what do you mean when you are talking about bleeding disorders?
A. It could be one of a number of different disorders. There are problems with the factors in the blood, clotting factors that people have. Sometimes they are born with these disorders, sometimes they acquire them. Also problems with blood platelets, which are another component of the blood that is important to cause the blood to be able to clot. People can be born with these problems or develop them, even develop them as a result of certain complications of pregnancy.
Q. Doctor, you also mentioned that patients with chorio-amnionitis would be offered particular advantages by undergoing an intact approach to D&E, is that correct?
A. Yes, that's correct.
Q. Just remind us briefly what chorioamnionitis is. I know we have defined it before, but there are a lot of medical terms here. Just for the benefit of the rest of us, can you briefly

[HAMMOND 589]

remind us what that is.
A. It is an infection of the fetal membranes and also the

amniotic fluid. We commonly, in case I lapse into this, will abbreviate it "chorio" for short.

Q. Why is it that a patient with chorioamnionitis would benefit from an intact approach to D&E?

A. There are a couple of reasons. First of all, these are patients who are already at higher risk of uterine perforation. If the uterus is infected, the wall doesn't have the usual turgor, the rigidity that it would have if it were not infected. Because of that, because of doing the procedure, as I testified, more intact decreases the likelihood of perforation, it is even more important in this kind of patient who is at higher risk.

There is another even more compelling reason, though. The more you manipulate the inside of the uterus when it is an infected environment, the more likely you are to seed the infection from the uterine lining into the blood and take a localized infection like chorio and make the patient septic, which I testified yesterday is a more disseminated infection and vastly more dangerous to the patient.

So when I am doing a D&E on somebody who has chorio, I am going to try to do the procedure with the minimum number of

24 passes, the least intrauterine instrumentation that I can, so
25 that I don't make the patient sicker in the process of doing

[HAMMOND 590]

1 this.
2 Q. Does a patient who has chorioamnionitis have to terminate
3 the pregnancy?
4 A. The pregnancy must be delivered, yes.
5 Q. Why is that?
6 A. Because it is the only way that you are really going to
7 eventually treat the infection. You must evacuate the uterus.
8 Q. Doctor, the last example that you gave us of situations
9 where a patient would benefit from an intact approach to D&E
10 because of a particular health condition was certain cardiac
11 anomalies or problems. Can you explain what you mean by that.
12 A. We see patients with lots of different heart problems. But
13 I think what I was thinking of originally are patients who have
14 certain severe cardiomyopathies. It could also be patients who
15 have severe valvular heart disease. The word "cardiopathy" is
16 essentially a problem with the heart muscle.
17 We see people who, because of a variety of conditions,

some that they are born with and others that they acquire, the heart loses its ability to pump as effectively as it should. So with each pump of the heart, they fail to expel, to propel, an appropriate quantity of blood. What you see in these patients is much like what you see in older patients who sometimes develop congestive heart failure: Their heart has pump failure and doesn't work.

We can see similar problems in people who have

[HAMMOND 591]

problems with the heart valves, the connections between the different chambers of the heart. There are a large number of these different problems, but they can either be too constricted or they can be too loose. As a result, the heart can have problems filling or it can have trouble pumping.

That is what I mean by the heart problems that I am talking about.

Q. Can you describe what the particular safety advantage would be of an intact approach to D&E.

A. I think that these are patients in whom, if you have a

hemorrhage, they are at even greater risk of dying. These patients do not tolerate fluid shifts well, and what might be a minor problem in any other patient rapidly becomes a major problem in these patients.

I like the control of D&E in general in these patients because I am able to have them in the OR at a predictable time with not only anesthesiologists but the cardiologists, and so forth, and I know exactly the 20-minute period of time when we are going to be evacuating the uterus.

But in terms of doing the procedure intact, this is the last patient in the world that I want to have a uterine perforation or a bad cervical laceration on. I want the best degree of control that I can possibly get surgically. And, as I testified, I can get that degree of control with an intact procedure, at least the most intact procedure I can get at the

[HAMMOND 592]

time.

Q. What are the benefits of that control of an intact procedure?

A. The benefits of the control are that I am not reaching into

the uterus and having to somewhat blindly go after disarticulated or dismembered parts. I can see and feel everything that I am doing, because it is closer to me. So I am never at as heightened a risk of perforating the uterus or lacerating the cervix.

Q. Doctor, you mentioned that you would have anesthesiologists and cardiologists with you in the OR during the 20-minute or so period of the D&E. What would their role be?

A. They are actually responsible for administering the anesthetic agents but also monitoring the patient's vital signs and their response to everything I am doing. It is really a division of labor. If I am tied up doing the procedure, and this is true of most surgeries, I can't moment to moment also be monitoring the patient's blood pressure and her fluid volume status, and so forth. So both the anesthesiologist and, in the case of a patient with a major heart disease, a cardiologist can help me do those things so I can concentrate on the surgery.

THE COURT: If you did an induction with a patient that had a heart problem, would you have a cardiologist there?

25 THE WITNESS: We would have consulted them. But there

[HAMMOND 593]

1 is no way of knowing if they would be there immediately at the
2 time of the delivery, because we never quite know when the
3 patient is going to deliver.
4 THE COURT: Once you knew there was going to be a
5 delivery, would you call upon a cardiologist?
6 THE WITNESS: We would certainly be calling them and
7 trying to get their advice by phone.
8 THE COURT: Or attendance, I assume, if you thought it
9 was necessary, right?
10 THE WITNESS: We would certainly try. But it is far
11 less predictable with an induction, because we don't know when
12 the patient is going to actually deliver.
13 THE COURT: Once you know that is happening, can't you
14 call? Isn't there a cardiologist on duty?
15 THE WITNESS: Yes, and we would call that person.
16 THE COURT: OK.
17 Q. Doctor, in situations of certain bleeding disorders, are
18 there medications that can be given a patient during the time
19 of the procedure that might assist you in alleviating the

concerns you have resulting from this health condition?

A. Yes, there are. It is actually advantageous when you are doing a D&E, because depending on the bleeding disorder, we can often give the patient those medicines immediately before the procedure, when she is most at risk.

For example, if a patient has extremely low platelets,

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PLAINTIFFS' EXHIBIT 125

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. MAUREEN PAUL 3/29/04

[PAUL 36]

IS VERY LOW.

AND THE OTHER THING IN GENERAL THAT YOU NOTICE IS THAT THE DEATH RATE INCREASES AS GESTATIONAL AGE INCREASES.

Q. ARE YOU LOOKING FOR THAT AT THE BOTTOM LINE, THE TOTAL?

A. THE TOTAL, YES. SO THESE ARE THE -- THIS IS THE TOTAL DEATH RATE FROM -- AT EIGHT WEEKS OR LESS, FROM ALL TYPES OF PROCEDURES THAT ARE DONE AT THAT GESTATIONAL AGE.

AND THE DEATH RATE IS 0.4 FOR 100,000. WHEREAS, IF YOU LOOK AT 21 WEEKS OR GREATER, AGAIN, THE RATE IS 10 PER 100,000 PROCEDURES.

Q. DOES THE LAWSON ARTICLE TELL US WHETHER THE RISK OF DEATH FROM ABORTION HAS CHANGED IN THE PERIOD SINCE ABORTION WAS LEGALIZED NATIONWIDE IN 1973?

A. IT'S NOT REFLECTED ON THIS TABLE, BUT THE ARTICLE TELLS US, YES, THAT THE RISK OF DEATH HAS DECREASED OVER 90 PERCENT, FROM ABOUT FOUR PER 100,000 IN 1972, TO ABOUT 0.4 IN 1987.

Q. DR. PAUL, EARLIER WHEN YOU WERE DISCUSSING THE SAFETY OF CARRYING A PREGNANCY TO TERM AND THROUGH CHILDBIRTH, YOU SAID THAT AS WOMEN GET OLDER THE RISK FOR CARRYING A PREGNANCY TO TERM INCREASES; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. IS THE SAME THING TRUE FOR ABORTION?

A. NO.

Q. IS THAT REFLECTED IN THE LAWSON ARTICLE?

A. WHEN THEY LOOKED AT THE MOST RECENT PERIOD OF 1983, 1987,

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[PAUL 76]

A. YES.

Q. WHAT DOES THE TERM "VAGINALLY DELIVERS" MEAN TO YOU AS AN OB/GYN?

A. "VAGINALLY DELIVERS" MEANS THE FETUS COMES OUT THROUGH THE VAGINA.

Q. AND WHAT DOES THE TERM "LIVING FETUS" MEAN TO YOU?

A. WELL, "LIVING" COULD BE WHEN THERE IS A HEARTBEAT DETECTED ON ULTRASOUND, WHICH COULD BE AS EARLY AS FIVE WEEKS GESTATION. "FETUS" USUALLY APPLIES TO THE PRODUCTS OF CONCEPTION AT 10 WEEKS AND UP. SO IF I PUT THE TWO TOGETHER, I WOULD SAY A FETUS AT 10 WEEKS GESTATION, OR MORE, THAT HAS A HEARTBEAT.

Q. AND YOU SAID THAT THE TERM "FETUS" WAS USED BEGINNING AT 10 WEEKS GESTATION; IS THAT RIGHT?

A. TEN WEEKS LMP, YES. BEFORE THAT THE PRODUCTS OF CONCEPTION ARE KNOWN AS AN EMBRYO.

Q. IN YOUR MIND IS THE TERM "LIVING FETUS" EQUIVALENT TO THE TERM "VIABLE FETUS"?

A. ABSOLUTELY NOT.

Q. IN THE D&E'S THAT YOU DO, DO YOU EVER DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVER A LIVING FETUS AS PART OF THE PROCEDURE?

A. YES.

Q. DR. PAUL, CONTINUING READING IN THIS DEFINITION, IT SAYS THAT -- JUST TO REPEAT WHAT WE HAVE ALREADY GONE OVER -- THAT:

"THE ABORTION OCCURS SUCH THAT THE PHYSICIAN

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PLAINTIFFS' EXHIBIT 126

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

[Title Omitted in Printing]

EXCERPTS FROM TESTIMONY OF DR. CAROLYN WESTHOFF 4/2/04

[WESTHOFF 834]

Q. Yes, Doctor.
THE COURT: Is this an appropriate time?
MR. HUT: I have about two more questions, or two more minutes, three more minutes, on this line. Then it would be a fine time, your Honor. But I'm happy to do whatever you want.
THE COURT: Go ahead, finish up this line.
Q. Dr. Westhoff, can you state whether in your opinion there are women with specific health conditions for which an intact D&E may offer safety or health advantages?
A. Yes.
Q. What are some conditions of maternal health for which an intact D&E may offer certain advantages, in your opinion, Doctor?
A. For those of my patients who arrive to be taken care of and already have serious medical conditions, and this includes

heart disease, sickle cell anemia, organ transplant, and a variety of other conditions, for those patients whose physiologic status is marginal at the start of the procedure, any complication is more catastrophic in their case. They would really be not in a good position to undergo additional surgery to care for the possible complications. In those cases I believe those patients have the most to gain from an intact D&E, where I would have an opportunity to avoid complications that in their medical condition would be unusually risky for them.

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[WESTHOFF 885]

complications were in the dismemberment group, and those actually are entirely analogous to the complications that we have observed in our own patient practice at Presbyterian.

Second, his overall conclusion is that the complication rates are the same in the two groups. But in his study the patients who underwent an intact D&E had a gestational age that was about two weeks greater than the

gestational age of patients undergoing dismemberment D&E. Since we do know based on other existing data that the risk of complications increases with advancing gestational age, I would expect to see more complications in the subgroup that had a more advanced gestational age. The fact that they had the same overall rate of complications is, I think, something that favors intact D&E as being a safer technique.

I think that supports --

THE COURT: Does that mean you disagree with Dr. Chasen's report?

THE WITNESS: I think Dr. Chasen --

THE COURT: Do you disagree, ma'am?

THE WITNESS: I agree with his results. I think his conclusions are too conservative.

THE COURT: So it is like a legal opinion, you agree in part and disagree in part?

THE WITNESS: Yes, your Honor.

THE COURT: We have a Court of Appeals that does that

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